BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, Petitioner,	)	
v.	)	DOCKET NO.: 20121145
JOHN SALINAS, M.D., Respondent.	)	

ORDER DENYING REHEARING

Respondent filed a motion for rehearing pursuant to Board Rule 360-26-.05 after the Final Decision was filed in this matter on September 21, 2018 and served on September 24, 2018. The motion was deemed timely filed. The motion for rehearing is denied, for reasons provided below.

Inappropriate Sanction.

In the motion for rehearing, Respondent argues that revocation, which was the sanction imposed by the Board in this case, was inconsistent with sanctions imposed by the Board in other cases decided by the Board. In support of his position Respondents refers to *GCMB v. David Williams, M.D.*, Docket No. 1620386 (2016); *In the Matter of Daniel Tesfaye*, M.D., Docket No. 10160025 (2016); and *In the Matter of Kevin McCowan, M.D.,* Docket No 20160035 (2018). In *Williams*, it was determined that the physician breached the standard of care in his treatment of his patient, and in the medical records he maintained for his patient. In *Tesfaye*, the Board found that the physician had inappropriately sexually touched one of his patients, and had previously engaged in similar conduct in another state. In *McCowan*, the Board concluded that the physician's negligent treatment of his patient caused or contributed to the patient's death. In none of these cases were the Respondents' licenses to practice medicine revoked.

Respondent's violations, in this case, of the Board's statutes, rules and the applicable standards of care, were far more numerous and wide ranging than those the violations in the cases cited by Respondent. As detailed in the extensive Initial Decision issued by the Administrative Law Judge, Respondent's violations consisted of

1. knowingly making misleading, deceptive, untrue, or fraudulent representations in the practice of his profession to both his patients and the Board;
2. engaging in unprofessional, unethical, and/or deleterious conduct or practice that were harmful to the public and departed from or failed to conform to the minimum standards of acceptable and prevailing medical practice;
3. committing acts and/or omissions that were indicative of bad moral character or untrustworthiness;
4. committing an act of sexual misconduct and/or exploitation of patients;
5. entering into conduct that discredited the medical profession;
6. failing to timely respond to an investigative subpoena issued by the Board; and
7. failing to adequately maintain or document his patients medical records.

Respondent's numerous and significant violations of the Board's statutes, rules, and the applicable standards of care, were as noted in the Initial Decision that was upheld in the Final Decision, far more "egregious" and "reprehensible" than those actions found in any single case Respondent cited. When a professional licensing board finds that any person should be disciplined the board is empowered to impose a wide range of sanctions, which include, but is not limited to revocation. O.C.G.A. § 43-34-8 (b)(1)(A through K).The Board's decision to

revoke Respondent's license in this case was within its power and was neither arbitrary, capricious, nor inconsistent with the sanctions it has imposed in other cases.

Failure to Permit Testimony at Review Hearing.

The Board's decision not to permit Respondent to testify during the hearing for Agency Review was not a violation of Respondent's due process. Board Rule 360-26-.04, which governs the review of the Initial Decision states in relevant part:

> (4) On review, the Board shall have all the powers it would have in making the initial decision, and in its discretion shall have the power to take additional testimony or remand the case to the original hearing officer for such purpose, as provided in the Administrative Procedure Act, O.C.G.A. 50-13-17 and in accordance with this Rule. Motions, including motions to present additional evidence, shall be filed in accordance with the time periods for such motions set forth in the Order scheduling the review.
>
> (a) Motions to present additional evidence or to remand the case to the original hearing officer for such purpose shall be granted only if the additional evidence is material and there was good cause for failing to present such evidence before the original hearing officer. All motions, including motions for the presentation of additional evidence, shall be ruled on by the Board, prior to oral arguments during the review hearing.

In this case, Respondent did not testify during the course of the six-day administrative hearing. Therefore, if Respondent wanted to testify during the hearing for agency review, which would amount to the presentation of additional evidence, he should have filed a motion to do so. Board Rule 360-26-.04. Respondent failed to present any such motion.

Even if Respondent had submitted a motion to present additional evidence, the Board would have granted it only if "the additional evidence is material and there was good for cause failing to present such evidence before the original hearing officer." Board Rule 360-26-.04. Since Respondent failed to submit a motion to present additional evidence, the Board could not have ascertained prior to the hearing if the additional testimony he sought to introduce at the

hearing would have been material. Furthermore, Respondent did not provide any reason for previously failing to present at the hearing held before the administrative law judge, the additional evidence, that being his testimony, which sought to introduce during the agency review. When a party attempts to introduce previously unsubmitted evidence in a motion to reconsider, the party is "obliged to show not only that this evidence was newly discovered or unknown to it until after the hearing, but also that it could not have discovered and produced such evidence' in the prior proceedings." *Coppage v. United States Postal Serv.*, 129 F. Supp. 2d, 1378 (M.D. Ga. 2001). For these reasons, the Board's decision not to permit Respondent to testify at the agency review hearing was correct and did not constitute a violation of Respondent's constitutional rights.

Material Fact Errors.

The Respondent alleged that the Administrative Law Judge and the Board overlooked key material facts in the Initial Decision and the Final Decision, respectively. Respondent further takes exception to several findings of fact and attempts to argue that the purported inconsistencies are grounds for rehearing. The Administrative Law Judge's obligation was to render findings in this case. The findings have a factual basis in the record and the Board will not disturb the well-reasoned findings provided in the Initial Decision. Furthermore, the credible evidence presented in this case proved beyond a preponderance of the evidence multiple grounds for revoking Respondent's medical license. Seeking to change or vacate a Final Decision based solely on different interpretations of the evidence is not the purpose of a motion for rehearing. Motions for rehearing are granted only in those instances when a material fact was overlooked or clearly misconstrued. Reconsidering "a previous order is an extraordinary remedy to be employed sparingly." *Coppage*, 129 F. Supp. 2d at 1379.

Influencing and Tampering of Witnesses.

Respondent alleged that one of the witnesses involved in this matter, L.C. engaged in tampering of other witnesses through intimidation. This matter was brought to the attention of the Administrative Law Judge, who addressed the matter. The Administrative Law Judge, who was in the best position to hear the arguments on this issue, made no determination that there was tampering and found that L.C.'s testimony was reliable. The Board has no basis on which to disturb the well-reasoned findings of the Administrative Law Judge and her handling of matters before her tribunal.

Conclusion.

In its motion for rehearing, Respondent has not demonstrated that the Board overlooked any material fact, controlling authority or any intervening change in controlling authority, that the Board or the administrative law judge made a clear error, that there was a manifest injustice, or that the legal authority was erroneously construed or misapplied. Respondent has failed to demonstrate that the either the Initial Decision or the Final Decision was erroneously entered. Therefore, Respondent's Motion for Rehearing is DENIED.

IT IS SO ORDERED this 8th day of November, 2018.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)

J. JEFFREY MARSHALL, M.D.
Chairperson

LASHARN HUGHES, MBA
Executive Director

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, Petitioner, v. JOHN SALINAS, M.D., Respondent.	))))))))	DOCKET NO.: 20121145

FINAL DECISION

An Initial Decision was docketed by the Office of State Administrative Hearings ("OSAH") in the above matter on June 18, 2018, and Respondent was served with the Initial Decision on or about that same day. On or about June 28, 2018, Respondent filed a Motion for Stay of Initial Decision, a Motion for Reconsideration, and a four page letter from Respondent in which he set forth his personal account of the facts and issues in the case, although he did not testify during the hearing. Petitioner filed responsive pleadings. On or about July 13, 2018, an Order was entered denying Respondent's Motion for Reconsideration, Respondent's Motion for Stay, and the Judge noted in her Order in Response to Petitioner's Motion to Strike Respondent's letter that the Court would not consider the letter submitted by Respondent.

On or about July 18, 2018, Respondent filed a Petition for Agency Review. The Board filed two separate Orders Extending Time for and Scheduling Review. A review hearing was held on September 14, 2018. Allen Meadors, Esq. was the appointed hearing officer. At the review hearing, the Board was represented by J. David Stubins, Senior Assistant Attorney General. The Respondent, John Salinas, M.D., was represented by Kelly Morton, Esq. After hearing argument and considering the matter, the Board finds as follows:

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

DECISION AND ORDER

Based on the foregoing Findings of Fact and Conclusions of Law as set forth in the Initial Decision, the Administrative Law Judge's recommendation that Respondent's medical license should be revoked as stated in its initial decision is adopted, incorporated by reference, and is hereby made the Final Decision of the Board as a matter of law under O.C.G.A. Sections §§ 50-13-17 and 50-13-41. Furthermore, this Order shall be considered a public record, and may be disseminated as such.

The Respondent's license is hereby **REVOKED**, effective upon docketing.

IT IS SO ORDERED this 21st day of September 2018.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)

J. JEFFREY MARSHALL, M.D.
Chairperson

LASHARN HUGHES, MBA
Executive Director

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD,
Petitioner,

v.

JOHN SALINAS, M D,
Respondent.

FILED OSAH JUN 18 2018
Kevin Westray, Legal Assistant

Docket No.: 1817535-OSAH-CSBM-PHY-60-Howells

INITIAL DECISION

The Georgia Composite Medical Board ("Petitioner" or "Board") initiated this matter for the purpose of sanctioning Respondent's medical license. Specifically, the Board seeks the revocation of Respondent's medical license.[1] The hearing was conducted on March 21-23, 2018 and May 9-11, 2018. The Board was represented by Senior Assistant Attorney General J. David Stubbins. Respondent John Salinas, M.D. ("Respondent") was represented by Kelly L. Morton, Esq. For the reasons stated below, this tribunal finds that Respondent's medical license should be **REVOKED**.

Findings of Fact

1.

Respondent is licensed to practice medicine in the State of Georgia and was licensed at all times relevant to the matters asserted. He has been licensed in this state since 1994. (Statement of Matters Asserted, ¶ 1; Answer to Matters Asserted, ¶ 1; Ex. P-1.)

[1] On or about February 14, 2018, the Board filed an Amendment to Matters Asserted in which it provided additional factual allegations regarding Patient L.C. On February 23, 2018, the Board filed a Second Amendment to Matters Asserted which added allegations as to a third patient, S.L. However, at the hearing, Respondent presented no testimony from S.L. and no expert testimony regarding Respondent's treatment of S.L. Respondent's only evidence regarding S.L. was an investigative file from Northside Hospital. For these reasons, the undersigned has concluded that the Board failed to present sufficient facts regarding S.L. Therefore, the undersigned has not made any findings of fact or conclusions of law regarding S.L.

Patient L.C.

2.

Respondent met L.C. in the late summer of 2006 at a Vanilla Ice concert. They began engaging in a sexual relationship toward the end of 2006. Respondent and L.C. dated for two to three weeks in 2006. The sexual relationship ended around August or September of 2006. Respondent provided no medical treatment for L.C. in 2006. (Tr. 42, 45-46, 163, 165-66.)

3.

In 2007, Respondent treated L.C. with weight loss injections. Also in 2007, he also performed microdermabrasion and removed a mole. In 2007, L.C. and Respondent were not dating. L.C. wrote Respondent a check in the amount of $500.00 for the treatment in 2007. (Tr. 167-69.)

4.

L.C. and Respondent again dated briefly in 2009. They resumed dating in November 2010 and stopped on December 31, 2010. In July 2011, they resumed dating and continued in that relationship until December 24, 2012.[2] (Tr. 360-61.)

5.

Between December 2010 and December 23, 2012, Respondent prescribed a multitude of medications for L.C., including clonazepam, phentermine, hydrocodone/ibuprophen, amphetamine salts, and Soma. (Ex. P-3, Tr. 570.) In addition, Respondent prescribed antibiotics, antivirals, birth control pills, skin treatments, and medications for weight loss. Over that period of time there were approximately twenty-six (26) new prescriptions (i.e., not refills). All of those prescriptions were given while L.C. and Respondent were involved in a sexual relationship. (Ex. P-3, Tr. 48-49, 56, 177, 571.)

[2] L.C. moved in with Respondent in April of 2012 and continued to live with Respondent until the relationship ended on

6.

On March 12, 2012, Respondent prescribed a breast ultrasound and a diagnostic mammogram for L.C. due to a nodule in her left breast. The prescription notes a diagnosis of fibrocystic disease. Respondent examined L.C. prior to writing the prescription. Respondent accompanied L.C. to Northside Hospital for the ultrasound and mammogram. The Northside Hospital medical records list Respondent as the admitting and requesting physician. (Exs. P-4, P-5; Tr. 50-55.)

7.

In mid-June of 2012, L.C. underwent liposuction at the office of Dr. Richard Mattison. Respondent told L.C. that he was going to perform the liposuction. He drove her to and from the surgery. L.C. did not have a conversation with Dr. Mattison about the surgery before or after it was completed. L.C. was not previously Dr. Mattison's patient. L.C. was unconscious during the liposuction. Lois Schofield was the nurse anesthetist responsible for the anesthesia during Petitioner's liposuction. According to Nurse Schofield, Dr. Mattison performed the procedure. Bates Mattison is the son of Dr. Richard Mattison. According to Bates Mattison, his father performed L.C.'s liposuction. (Tr. 57-60, 63, 822, 855-57.)

8.

On July 10, 2012, L.C. had a motor vehicle accident (MVA) in which she was struck from behind, in Charlotte, North Carolina. On July 11, 2012, L.C. went to the emergency room at the Central Carolina Hospital for the discomfort she was having as a result of the MVA. She drove back to Atlanta on July 13, 2012. Respondent recommended that L.C. keep a journal of the symptoms she was experiencing as a result of the MVA and to track the progress of her treatment. (Ex. P-10; Tr.

December 24, 2012. (Tr. 46, 361.)

67-81.)

9.

Respondent began treating L.C. for the discomfort associated with the MVA on August 2, 2012. On that date, L.C. received ultrasound treatment. Between August 2, 2012 and September 3, 2012, L.C. had approximately six appointments in Respondent's office for treatment of her discomfort related to the MVA. During some of the visits she received ultrasound from one of the women in the office and on two occasions Respondent gave her trigger point injections. In addition, Respondent referred L.C. to Dr. Karen Joanson. Dr. Joanson is a chiropractor. L.C. treated with Dr. Joanson from August 3, 2012 through May 27, 2014. (Tr. 68, 76, 84, 87-89; Exs. P-7, P-10, P-12.)

10.

In late August 2012, L.C. began having symptoms that caused her to wonder whether she was pregnant. She subsequently learned that she was, in fact, pregnant with Respondent's child. On September 18, 2012, L.C. became concerned because she was spotting and sent text messages to Respondent about her concerns. Respondent performed an ultrasound and blood work on L.C. in his office on September 26, 2012. On a subsequent evening, L.C. expelled a large amount of thick gel-like blood while she was in the shower. She told Respondent about it and he told her that she had just aborted the baby. (Tr. 110-114, 117; Exs. P-13, P-14, P-16.)

11.

A few days later, on September 29, 2012, L.C. began having severe pain, lightheadedness, bloating, and weakness. Respondent contacted Dr. Joseph Boveri and told him that he wanted to refer L.C. to him for a possible ectopic pregnancy. Respondent then took L.C. to the Saint Joseph's Hospital Emergency Room. Respondent completed the admission paperwork. He provided L.C.'s address as 2944 Winterhaven Court, which is the address where they resided together. He also listed

himself as L.C.'s next of kin and emergency contact. (Tr. 118-122, 876-77; Ex. P-15.)

12.

While L.C. was in the hospital, it was determined that she had a ruptured ectopic pregnancy. Dr. Boveri performed an endometrial curettage, a laparoscopic salpingotomy, and evacuation of ectopic pregnancy and hemoperitoneum. (Tr. 124, 881; Ex. P15.)

13.

On October 14, 2012, Respondent called the police and reported that L.C. was trespassing, had threatened him with a butcher knife, and damaged property. As a result, L.C. was arrested for two counts of Criminal Trespass and one count of Disorderly Conduct. (Tr. 259-62; Ex. R-7.) At the time, L.C. will living with Respondent. Subsequently, Respondent wrote an affidavit in which he stated, as follows:

> This is to certify that [L.C.] was not trespassing on 2944 Winterhaven Ct., Atlanta, Georgia 30360 on October 13-14, 2012 or any other day for that matter. Ms. [C] was residing at the aforementioned address at the time of the incident. Ms. [C] still resides and receives mail at the said address. There was no damage at the residence caused by Ms. [L.C.]. It was never my desire, request, or intention that Ms. [C] be arrested or charged with any crime. Ms. [L.C.] is a wonderful law abiding person. I vehemently support Ms. [L.C.'s] innocence on these charges and request that all charges be dropped.

(Ex. P-21.) The charges against L.C. were dismissed. (Ex. R-7.)

14.

On or about December 19, 2012, L.C. observed Respondent working on a report regarding his treatment of her for the MVA. (Tr. 206.)

15.

Around December 21, 2012, Respondent went out of town with his mother. L.C. remained at their residence to watch Respondent's mother's dog. While he was out of town, L.C. began

receiving "violent" text messages from Respondent. L.C. decided that she had had enough. She started packing her things. She called Respondent's friend Benjamin Bagwell to come get the dog. After Respondent dropped his mother off in New York City, he apparently turned the car around and returned home. Early in the morning, on December 24, 2012, Respondent arrived at the residence. He attempted to have sex with L.C. and when she did not agree, he told her that he was going to call the police and report that she hit him. Respondent did in fact call the police to report a domestic violence incident. (Tr. 271-73.)

16.

When the police arrived at the residence, Respondent reported that he learned that L.C. had "contact with males and used illicit drugs." He reported to the police that he asked her to vacate the premises and that she "kicked" him in the chest. The police noted no signs of an altercation or injury to Respondent. While speaking with Respondent, the officer noted that Respondent began altering or recanting his allegation that L.C. assaulted him. L.C. then explained her version of the events and showed the officers a text message from Respondent stating that she would "pay." The officers observed no direct threat of violence with any text messages. L.C. vacated the premises with her remaining property. (Ex. R-9.)

17.

After the break up on December 24, 2012, Respondent continued to text and call L.C. numerous times per day. (Tr. 93.)

18.

L.C. had previously hired Morgan and Morgan to represent her for the MVA. The law firm attempted to obtain her medical records from Respondent to no avail. On January 11, 2013, L.C. asked Respondent's friend and sometimes attorney Benjamin Bagwell to implore Respondent to send

her medical records to Morgan and Morgan. Mr. Bagwell forwarded the email to Respondent and, in turn, Respondent sent an email directly to L.C. In the email, Respondent asked L.C. to fax her insurance information and the dates that she recalls being seen. Respondent specifically referenced her log (i.e., the journal he advised her to keep to track her symptoms and treatment). (Tr. 71-72; Ex. P-9.)

19.

L.C. filed a complaint with the Georgia Composite Medical Board on January 22, 2013. The crux of her complaint was that she was unable to obtain medical records from Respondent for treatment he had rendered. She also noted that they had been in an intimate relationship. (Tr. 98, 684.)

20.

On January 25, 2013, at 1:50 p.m., Respondent sent L.C. a long email professing his love for her. L.C. did not respond to the email. At 2:25 p.m., that same day, Respondent sent L.C. a text message, in which he states, "[L], in order for me to send any information out about you, I need a lien signed and mailed back. There is not one in your folder. I will include it in the box that I mail to you. . . ." When L.C. did not respond, Respondent sent a text message at 2:33 a.m. on January 26, 2018, asking L.C. if she was OK. L.C. subsequently asked Respondent to stop trying to contact her and especially at 2:30 in the morning. (Tr. 133-37; Exs. P-11, P-17.)

21.

On January 26, 2013, L.C. filed a police report regarding the continued text messages. The police purportedly spoke with Respondent and Respondent stated that he would not contact L.C. except through attorneys. (Tr. 138; Ex. P-19.)

22.

Respondent provided Morgan and Morgan with a letter dated February 7, 2013. The letter stated as follows:

> This is to certify that Ms. [L.C.] had a motor vehicle accident on 7/10/2012 in North Carolina where she was struck from behind. Ms. [C] is an old acquaintance. I can certify that she had whiplash and lumbago. I recommended that she go to Karen Joanson Scott, Chiropractor at Buckhead Family Chiropractic for treatment. There has been no treatment and there is no charge from my office. She was treated at Central Carolina Hospital in Sanford North Carolina where you may obtain treatment records.

(Ex. P-8.)

23.

Also on or about February 7, 2013, Respondent was interviewed by members of the Board about a patient M.A. Respondent's attorney Benjamin Bagwell was present during the interview. At that time, some questions regarding L.C. were raised. (Exs. P-32, P-34, P-35.)

24.

On February 21, 2013, beginning at 2:24 p.m., Respondent sent L.C. the following text messages:

> You're a fat, aging, vengeful, balding, bitter, loser friends, cheater, unorganized, smoking bad breath, cocaine addict, ALCOHOLIC, sneaking liar, hairy ass, cellulite body, [d]ouble chin, acne faced, scar faced freak . . . you deserve your bad karma . . .
>
> Wrinkled eye, Moody bitch too
>
> Nobody wants you anyway . . . except for a one night stand . . . I am done with your Moody bipolar psycho bullshit . . . you are CRAZY . . . everyone [i]s right about you . . . all those years of cocaine . . . you are not normal . . . good riddance loser[.]

(Ex. P-20; Tr. 145-46.) Later that same day, L.C. filed a police report regarding the ten texts and twenty-one phone calls that she received from Respondent that day. (Tr. 42; Ex. P-18.)

25.

Within a few days, Respondent tricked L.C. into answering his call. He told her that her friend Brittany was going to be calling her. After L.C. answered the phone, Respondent asked her not to hang up. He told her that he would provide her medical records if she agreed to meet him. (Tr. 97.)

26.

L.C. met Respondent at a restaurant on February 25, 2013. L.C. recorded the entire conversation. Respondent did not provide L.C. with a copy of her medical records. Instead, he told her that he would do so when Board's investigation died down. He also told her that during his meeting with the Board members he told them that she was only a friend, because he did not want to get in trouble. When L.C. complained that all he did for her back was give her injections to numb it, Respondent disagreed and corrected L.C. He said that the trigger point injections were a treatment for pain control. (Ex. P-12, 40:00 – 50:00.)

27.

It is unclear whether Respondent was aware that L.C. had made the complaint with the Board or whether it was her Morgan and Morgan lawyer who filed the complaint. During the February 25, 2013 conversation, Respondent repeatedly professed his love for L.C. and told her that he would take her back in a heartbeat. He also tried to persuade L.C. to fire her Morgan and Morgan lawyer and hire his friend Ben Bagwell to represent her in the lawsuit regarding her MVA. He was concerned that if her current lawyer obtained her medical records that the lawyer would provide them to the Board. He further admitted that he had started working on the medical report concerning her MVA in L.C.'s presence and that he later completed it. He stated that he would like to get paid and that if she hired Mr. Bagwell, they would all get paid. Respondent stated that he overreacted and that he

made a mistake when he called the police on December 24, 2012, in essence admitting that his statement to the police about L.C. hitting him was false. He told L.C. that he said the nasty things about her in the February 21 text messages to make her insecure; so she would not go find a new boyfriend. (Ex. P-12, at 30:00 – 59:00, 1:23:00 – 1:24:00; Tr. 236.)

28.

On March 6, 2013, the Board sent an investigative subpoena to Respondent, requesting a certified copy of the complete medical records file for L.C.[3] On March 21, 2013, Respondent's attorney Benjamin Bagwell sent a letter to Agent Cleary in response to the March 6, 2013 subpoena. In the letter Mr. Bagwell stated that he represents Respondent generally and in this matter before the Board. He further stated, in pertinent part, as follows:

> This response to your letter dated March 6th, 2013 is in regard to a Complaint apparently filed by [L.C.]. As I believe was stated in person to you or maybe a colleague, Ms. Roberts, on February 7th, 2013, Ms. [C] is not a patient of Doctor Salinas. As such there are no medical records pertaining to an accident on or about July 10th, 2012, or at any time. Ms. [C] is a former "friend of interest" or girlfriend of Doctor Salinas. In the middle of December 2012, Doctor Salinas and Ms. [C] ended their relationship; therefore, their relationship was not inappropriate, and the allegations that Ms. [C] was a patient are incorrect. The relationship between the two principals was very tenuous over time. Ms. [C] has been treated by other doctors for her accident and other medical problems. Doctor Salinas did not meet Ms. [C] in a medical setting, but rather in a public event many years ago.

(Tr. 684-86, 689-91; Exs. P-31, P-32.)

29.

In November of 2015, Board Enforcement Supervisor Patricia Sherman sent an email to Respondent, asking him to come in for an interview regarding the L.C. complaint. After some emails back and forth, Respondent declined to come in for an interview. Respondent asserted that he

[3] Although Respondent's address on the subpoena and cover letter contain a typographical error, it is clear that Respondent did receive the subpoena, albeit two weeks later, as his attorney refers to the letter in his response. Furthermore, it is clear that the cover letter and the subpoena were requesting a copy of the **complete** medical records file

previously discussed L.C.'s complaint with the Board and that he was allegedly told that the matter was dismissed. (Tr. 696-98; Ex. P-33.)

30.

Karl Reimers is the Director of the Office of Investigations and Enforcement for the Board. He began working in that capacity in October 2015. At that time, he assumed control of the investigation of L.C.'s complaint. On December 10, 2015, Mr. Reimers sent a letter to attorney Benjamin Bagwell regarding the Board's investigation of L.C.'s complaint. The letter was mailed to the P.O. Box address that was on Mr. Bagwell's March 21, 2013 letter. In the letter, Mr. Reimers stated that the Board obtained prescription logs indicating that Respondent prescribed twenty-one (21) prescriptions for L.C. between September 2011 and April 2013. Additionally, the Board obtained a receipt from Waterford Medical Care, which is the name of Respondent's medical practice, in the name of L.C. for an office visit on September 26, 2012. Given Mr. Bagwell's previous statement that L.C. was Respondent's girlfriend and not a patient, the Board was requesting that Respondent provide an explanation for the multiple prescriptions and office visit. (Tr. 682-683, 706-710; P-35.)

31.

Mr. Reimers did not receive a response to his December 10, 2015 letter. In January of 2016, Mr. Reimers called Mr. Bagwell and spoke briefly with him on the phone. He told Mr. Bagwell about the letter he sent in December and the address to which he mailed it. Mr. Bagwell told him that he did not receive the letter. During the phone conversation, Mr. Reimers confirmed Mr. Bagwell's email address. He followed up the phone conversation with an email to the address provided by Mr. Bagwell on January 13, 2016. The email explained that the case was moving

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for L.C., not solely medical records related to her MVA. (Tr. 686; Ex. P-31.)

forward. Mr. Reimers attached copy of the December 10, 2015 letter to the January 13, 2016 email. (Tr. 720-22; Ex. P-36.)

32.

After receiving no response to the January 13, 2016 email, Mr. Reimers drafted a second letter on February 10, 2016. The letter was to notify Mr. Bagwell and Respondent that the case was going to be presented to the Board to determine what action it deemed appropriate. The letter was mailed to the P.O. Box address on Mr. Bagwell's previous correspondence and also emailed to the email address provided by Mr. Bagwell in January 2016. Ultimately, the Board never received any medical records for L.C. from Respondent. (Tr. 722-725; Ex. P-37.)

33.

Doctor Roger Hill is a board certified family practice physician with 39 years' experience. He has previously served as a peer reviewer for the Board approximately twelve times. With regard to this matter, Dr. Hill completed a peer review of Respondent's treatment and care of L.C. (Tr. 568-570.)

34.

Dr. Hill opined that because Respondent ordered tests, rendered a diagnosis, and prescribed medications for L.C., she was, in fact, a patient. (Tr. 575-78.) According to Dr. Hill, Respondent's treatment of L.C. fell below the standard of care when he engaged in the following unprofessional conduct: (1) he treated L.C. as a patient while they were engaged in a sexual relationship;[4] (2) he failed to maintain medical records to support his prescription of medications, including controlled substances; (3) he failed to maintain a medical record to support the ordering of a breast ultrasound

[4] Dr. Hill elaborated that it is not appropriate to have sexual relations with someone with whom you are trying to objectively treat as a patient. Dr. Hill did acknowledge that physicians can write a prescription for a loved one on an urgent basis. (Tr. 572, 579-80, 650-51.)

and diagnostic mammogram; (4) he failed to maintain a medical record when making the diagnosis of "lumbago;" and (5) he failed to use a proper history, physical, laboratory tests, and radiological procedures to make a diagnosis. (Tr. 573-81.)

Patient A.K.

35.

A.K. met Respondent in approximately 2010.[5] Thereafter, Respondent pursued A.K., but she was not interested. (Tr. 368, 372.)

36.

In or around 2012, A.K. was in between jobs and did not have medical insurance. She previously had been diagnosed with cervical cancer while she was living in Connecticut and had been advised to have a yearly gynecological exam and pap smear. Respondent offered to do the examination and pap smear for a nominal fee. A.K. accepted his offer. When A.K. went to Respondent's office, there was a patient in the waiting room and a woman behind the front desk. Respondent first attended to the other patient. After that patient left the office, A.K. went into one of the examination rooms with an exam table with paper on it. Respondent performed the examination and the pap smear, which was to be sent to a laboratory. No one else was in the examination room during the examination. After the examination, Respondent commented that he and A.K. should have a baby. Respondent was also aware that A.K. had consumed some wine earlier and was a little "tipsy." Thereafter, Respondent and A.K. had sex in the exam room. (Tr. 371-377.)

37.

A.K. and Respondent dated casually on and off for a few months after the encounter in his office. A.K. characterized the physical relationship as a fling. Approximately a year after it ended,

[5] Michele Ostrander testified that A.K. met Respondent in 2007 and that they dated on and off from 2007 until 2010. (Tr.

Respondent contacted A.K. and asked her to lunch. A.K. agreed to meet Respondent and they went to lunch on April 12, 2013. (Tr. 378, 381-83.)

38.

During the lunch, Respondent asked A.K. if she would hang out with him and some of his friends that evening. A.K. agreed to do so; however, Respondent had to see a patient at his office before they could go out. Respondent told A.K. that he did not have anyone working at the office at that time. He asked A.K. if she would poses as his receptionist and in exchange he would give her Botox. A.K. agreed and accompanied Respondent to his office. While they were on the way to the office, Respondent told A.K. that he had been experimenting with something new and getting good results. Respondent showed A.K. pictures of purported patients on whom he used the experimental treatment to plump up their butts. Respondent then told A.K. that she had a flat butt and that he could give her these injections to plump up her butt. A.K. agreed to the free injections in exchange for posing as his receptionist. (Tr. 383-85.)

39.

Once they were at Respondent's office, a female patient arrived. A.K. posed as Respondent's receptionist and Respondent attended to the patient. After the patient left the office, Respondent locked the door. There was no one else in the office beside Respondent and A.K. Respondent took A.K. into one of the examination rooms.[6] He then began to explain a little more about the injection.

788-90.)

[6] At the hearing, Respondent presented the testimony of medical assistant Doris Calderon-Perez. Ms. Calderon-Perez testified that she was working in the office on the day A.K. received the injections, she took A.K. into the examination room, she gave A.K. new patient form to complete, she put the new patient form in A.K.'s folder, Respondent injected A.K. with Depo-Provera because A.K. complained of "nightmare" menstrual cycles, Respondent came into the examination room at approximately 4:45 p.m., while in the examination room A.K. also complained about dimples on her buttocks, Respondent injected normal saline into A.K.'s buttocks, she was present during the injections, and Respondent finished with A.K. at approximately 6:00 p.m. (Tr. 1010-18, 1034-1050.) Ms. Calderon-Perez also testified that she took handwritten notes during A.K.'s visit and that she typed her notes before she left and after A.K. pulled up her pants. (Tr. 1042-46.) However, Ms. Calderon-Perez's testimony was riddled with internal inconsistencies, implausibility, and

He told her that he gets the substance from Peru or Costa Rica. He did not tell her the name of the substance, but he told her it was safe.[7] The only risks Respondent told A.K. about were redness at the injection sites and difficulty sitting for a day of two. He did not have her sign an informed consent document. (Tr. 385-87.)

40.

While A.K. was in the examination room, Respondent retrieved a machine. He did not take her blood pressure prior to giving her the injections. A.K. pulled her jeans down, but because she was wearing thong underwear, she did not need to pull her underwear down. With a pen, Respondent marked the locations where he was going to inject the substance. A.K. was bent over an exam table when Respondent turned on the machine. A.K. recalls the machine making a "motor-like" noise. Respondent made the first injection into A.K.'s left buttock. After the second injection into A.K.'s left buttock, she felt a strange tingling sensation in her head. She told Respondent to stop the injections. (Tr. 387-91.)

41.

A.K. had an adverse reaction to the injections. At some point, Respondent called 911, due to the reaction A.K. was having. Emergency medical services were dispatched from DeKalb Fire Rescue at 6:26 p.m. Paramedic Kenneth Ranalli and his partner Brian Leheny arrived at Respondent's office at 6:39 p.m. Respondent reported to Paramedic Ranalli that he was treating

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is contradicted by other evidence. For example, at one point, she claimed that all of the information in the Incident Progress Note (Ex. P-27) was information that she typed while A.K. was still present and before Ms. Calderon-Perez left the office at approximately 6:15 p.m. However, the Incident Progress Note contains information that was "obtained" after Ms. Calderon-Perez allegedly left the office. She also testified that when A.K. completed the new patient form she would have provided next of kin and the name and phone number of an emergency contact. However, it is later urged by one of Respondent's other witnesses that Respondent contacted him for emergency contact information. For these reasons, the undersigned did not find Ms. Calderon-Perez's testimony regarding A.K. to be credible.

[7] A.K. did not ask for birth control and Respondent did not tell A.K. that he was going to inject her with Depo-Provera or any type of birth control. A.K. knows what Depo-Provera is. She received it in her early twenties and did not have a good experience with it. She recalls losing some hair and gaining a significant amount of weight. (Tr. 400-01.)

A.K. for a dimple on her buttock with a 300cc intramuscular injection of normal saline and that shortly after the injection A.K. started having seizure-like activity. Respondent did not tell Paramedic Ranalli that he had injected A.K. with Depo-Provera. Respondent did not inform Paramedic Ranalli that A.K. may be having an allergic reaction to illicit drugs or some other drug. Nor did he report that he was treating A.K. because she had allegedly irregular menstrual cycles or that she wanted to gain weight. (Tr. 389, 456-70; Ex. P-29.)

42.

When Paramedic Ranalli arrived on the scene, it appeared to him that A.K. was having what appeared to be a combative reaction as opposed to a seizure. On his initial assessment of A.K., she was not responsive and her Glasgow score was an eight (8).[8] The normal Glasgow score is fifteen (15). Paramedic Ranalli told Respondent that he was going to take the IV bag of normal saline that was used to for the injection. Paramedic Ranalli and his partner transported A.K. and the bag of normal saline to Northside Hospital. (Tr. 464-72; Ex. P-29.)

43.

After arriving at Northside Hospital Emergency Department, Paramedic Ranalli observed Respondent providing information to the charge nurse, another nurse, and the physician. The emergency room physician noted that A.K. could tell him her name and that she was at Northside, but that she was having difficulty completing sentences and talking to him beyond that. Respondent was at the bedside with A.K. He reported to the emergency room physician that A.K. saw him in his office today to have a procedure regarding a skin lesion. He further reported that "[p]rior to the procedure, he injected some saline subcutaneously in her buttock to 'raise the lesion.'" Respondent reported that after the procedure, A.K. began "acting in a bizarre manner and became combative and

[8] The Glasgow score is used to assess a patient's neurological status. (Tr. 472.)

altered." Respondent further reported that A.K. was "fine" prior to the procedure. The physician noted that A.K. was not known to have any substance abuse issues. There is no mention of Depo-Provera in the Northside Hospital records.[9] (Tr. 471; Ex. P-22.)

44.

While at Northside Hospital, A.K.'s blood alcohol level was negative and her urine drug screen was negative. The urine drug screen tested for amphetamine, barbiturates, cocaine, phencyclidine, benzodiazepines, opiates, and cannabinoids. None were present in A.K.'s urine. (Ex. P-22.)

45.

When A.K. was coming to, she saw Respondent at her bedside. Respondent asked to get A.K.'s phone out of her purse to get her father's phone number. After doing so, Respondent was able to contact A.K.'s father to let him know she was in the hospital. (Tr. 549-50.)

46.

While still at the hospital, Respondent told A.K. and her father that he was going to pay the medical bills associated with her treatment at Northside Hospital. Respondent did not pay those medical bills. (Tr. 417, 422.)

47.

As a result of the reaction A.K. had to the injections at Respondent's office, A.K. sustained a bruise on her right forehead, abrasions on her right ankle, bruising on her left inner elbow, an abrasion on her right outer elbow, and bruising on her right buttock. In addition to the bruising on

[9] As noted above, A.K. did not ask for birth control. (Tr. 400-01.) On the day A.K. had the adverse reaction Respondent said nothing to A.K., the EMS personnel, or the Northside Hospital emergency room physician about Depo-Provera. (Tr. 400-01, 467; Exs. P-22, P-29.) Further, the supposed medical record that mentions the Depo-Provera was not produced to the Board until more than three months after it was requested. (See infra.) For these reasons, the undersigned finds that Respondent did not, in fact, give A.K. a Depo-Provera injection.

her right buttock, multiple injection points were visible a day or so after the injections. It appears that Respondent continued to inject A.K. with some substance after the second injection to the left buttock when she asked him to stop. (Ex. P-23; Tr. 419-21.)

48.

Sometime after the April 12, 2013 incident at Respondent's office, A.K. met with attorney William McKenney regarding a possible medical malpractice lawsuit against Respondent. A.K. subsequently retained Mr. McKenney and authorized him to obtain her medical records from Respondent. (Tr. 427-28, 484; Ex. P-25.)

49.

On July 23, 2013, Mr. McKenney sent, via certified mail, a request for all of A.K.'s medical records. Enclosed with the request was the authorization for Respondent to disclose health information to Mr. McKenney and a form for the custodian of records to certify the authenticity of the records. The certified letter was returned to Mr. McKenney's office with a notation that it had been refused on July 25, 2013. Mr. McKenney also left two voice messages for Respondent, to which Mr. McKenney did not receive any response. (Tr. 489-491; Ex. P-25.)

50.

Mr. McKenney subsequently drafted a letter for A.K. to send directly to Respondent in which A.K. requested a copy of all of her medical records. That letter was sent on August 15, 2013. In addition to the letter, A.K. called Respondent and left messages regarding her medical records. She also asked their mutual friend, attorney George Plumides, to ask Respondent to provide her with her medical records. A.K. never received a response to her request for her medical records. (Tr. 432-33, 493; Ex. P-26.)

51.

Subsequently, after filing the lawsuit, Mr. McKenney hired three different investigators who made numerous attempts to serve Respondent with the summons. On one occasion, one of the investigators observed Respondent outside of his home. The investigator apparently yelled to Respondent that he had some papers for him, and Respondent took a few running steps, got into the vehicle, and the woman driving the vehicle drove away. Mr. McKenney spent over $3,000.00 trying to serve Respondent with the summons. He also contacted the DeKalb County Marshall's Office and asked them to attempt service. The Marshall's Office made seven attempts, to no avail. (Tr. 498-500, 510-12; Ex. P-30.)[10]

52.

In December of 2013, A.K. filed with the Board a complaint against Respondent. The complaint related to the injection A.K. received from Respondent and her subsequent inability to obtain her medical records. (Tr.745-46.)

53.

After receiving A.K.'s complaint, the Board opened an investigation. As part of that investigation, on January 21, 2014, the Board sent an investigative subpoena to Respondent requesting a certified copy of A.K.'s complete medical records file within 10 day of receipt of the subpoena.[11] On February 3, 2014, the Board received a letter from Respondent's attorney Benjamin Bagwell. (Tr. 748-49; Exs. P-28, P-38.) In the letter, Mr. Bagwell states that he represents Respondent generally and in this matter. Attorney Bagwell then states, in pertinent part, as follows:

[10] In thirty-five years of practice, this is the first time Mr. McKenney has not been able to perfect service on a defendant. In his opinion, Respondent was avoiding service. Ultimately, Ms. A.K.'s lawsuit was dismissed for lack of prosecution. (Tr. 498, 501, 510.)

[11] Although the investigative subpoena contained a typographical error in Respondent's address, it is clear that he received the subpoena, as his attorney references it in his February 3, 2014 letter.

> It is my understanding that in regards to Miss [A.K.] and the incident in question, Doctor Salinas injected depoprovera 150 mg with saline in the buttocks as a courtesy per Miss [K's] request. Miss [K] subsequently experienced violent behavioral manifestations after five minutes, specifically kicking the walls of the treatment and office examination room. It was at this time Doctor Salinas called Emergency Medical Services, who upon arrival restrained Miss [K], and she was taken to the nearest hospital. Doctor Salinas went directly to the hospital too. While at the hospital, Miss [K] disclosed that she had used illicit drugs earlier that particular day.[12] This information was not disclosed to Doctor Salinas in his examination dialog and interview with Miss [K] prior to her treatment. Coming to light since the incident in question, Miss [K] has been reported to have had prior violent responses, at the home of Mr. Joseph Babb, after hormone therapy mixed with illegal drug use.

(Ex. P-28.) No medical records were provided with Mr. Bagwell's letter. (Tr. 752.)

54.

On March 27, 2014, Board Agent Edva Smith sent an email to Mr. Bagwell, again requesting a complete copy of A.K.'s medical records. On March 28, 2014, Mr. Bagwell responded to Agent Smith's email and stated, in pertinent part, as follows: "I will inquire about this topic this morning on my way to one of four Courthouses I need to appear at this morning, and today. I will obtain what Dr. Salinas has and forward that material to you as an e-mail attachment as soon as practical. In the event he has none, I will let you know but, I do believe he has some cursory notes in a file for her." (Ex. P-39; Tr. 754-56.)

55.

The Board received no further response from Mr. Bagwell or Respondent in the remaining few days of March or in the month of April 2014. Because Agent Smith had not received a response from Mr. Bagwell or Respondent regarding A.K.'s medical records, she conferred with another Board agent, Emily Kirkland. On May 8, 2014, Agent Kirkland placed a call to Mr. Bagwell and left a message regarding the subpoena. That day, Agent Smith received a one-page Incident Progress

[12] A.K. did not disclose that she had used illicit drugs that day because she did not do so. (Tr. 444, 448; see also Urine Drug Screen contained in Ex. P-22.)

Note via fax. The original Incident Progress Note was received on May 13, 2014. (Tr. 756-58; Ex. P-40.)

56.

The one-page Incident Progress Note is typed and undated. A.K.'s last name is misspelled. Under a subheading of "Subjective," the notes states, "Wants to gain weight. Has other doctor but wants shot to gain weight." Under the subheading of "Assessment Plan," the notes states as follows:

> Healthy female. Has lost weight after losing job. Stressed. History of recent menstrual irregularity.[13] No specific complaints otherwise. Discussed possible benefit of depoprovera to help diminish period and gain weight. After verbal consent injection medroxyprogesterone 150mg on bilateral gluteal area 75mg, Green Valley brand had aggressive reaction with yelling and kicking walls but responsive x3. No rash or edema. Refrained from giving any meds. Called EMS for transfer to northside hospital for observation. After 5 hours at Northside, patient was released. After discussion with her attorney George Plumides, patient has history of aggressive reaction to hormones with destruction of property.[14] After discussion with attorney Paul Roman, there appears to be undisclosed drug use by Ms. [K].[15] Possible cross interaction. No evidence of allergic reaction.

(Ex. P-27.) The Board never received a complete medical record from Respondent. (Tr. 752.)

57.

Doctor Roger Hill also completed a peer review of Respondent's care and treatment of A.K. According to Dr. Hill, Respondent's care and treatment of A.K. fell below the standard of care when he engaged in the following unprofessional conduct: (1) he performed a gynecological examination on A.K. without a female chaperone present; (2) he had sex with A.K. after performing a gynecological examination; (3) he failed put a date on the purported record of the injections and A.K.'s subsequent reaction; (4) he failed to perform a gynecological examination, pap smear and

[13] A.K. did not complain of an irregular menstrual cycle. She has never had an irregular menstrual cycle. (Tr. 435, 441.)
[14] George Plumides was not A.K.'s lawyer at this time. The only time he represented A.K. was in 1992. A.K. did not give Respondent permission to discuss her care and treatment with George Plumides. (Tr. 442-43, 938.)
[15] A.K. did not give Respondent permission to discuss her care with attorney Paul Roman. (Tr. 444.)

mammogram before purportedly administering an initial injection of Depo-Provera;[16] Dr. Hill also testified that the only use of Depo-Provera is birth control. Weight gain is a side effect of the medication. Another side effect is irregular vaginal spotting. Thus, if a patient is complaining of irregular menstrual cycle, Depo-Provera would not be an appropriate form of birth control. (Tr. 570, 582-86, 598-604, 607-09,616-20; Ex. P-27.)

Conclusions of Law

1.

Petitioner seeks the revocation of Respondent's medical license. Accordingly, Petitioner bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21.

2.

The trier of fact determines the credibility of witnesses and the weight to be given their testimony, and is not obligated to accept a witness's testimony, even if it is uncontradicted, and may accept or reject all or part of the testimony. O.C.G.A. § 24-6-630; Tate v. State, 264 Ga. 53 (1994); State v. Betsill, 144 Ga. App. 267 (1977). In non-jury cases that determination lies with the judge. *See Mustang Transp., Inc. v. W.W. Lowe & Sons, Inc.*, 123 Ga. App. 350, 352 (1971).

3.

To resolve the direct conflict in the sworn testimonies of the witnesses, the undersigned considered all the facts and circumstances of record in this matter. The undersigned considered the witnesses' manner of testifying, their intelligence, their means and opportunity of knowing the facts to which they have testified, the nature of the facts to which they have testified, the probability or

[16] Dr. Hill elaborated that prior to giving any kind of birth control the physician should order a mammogram and perform a pap smear, to determine if there is an breast or cervical cancer, because the hormones in the birth control can accelerate cancer. (Tr. 616, 619.)

improbability of their testimony, their interest or want of interest and their personal credibility. O.C.G.A. § 24-14-4.

Violations

4.

Georgia Code section 43-34-8(a), which is the specific licensing and disciplinary statute for the medical profession, states, in pertinent part, that the Board has the authority to discipline a licensee, upon a finding that the licensee has:

* * *

> (2) Knowingly made misleading, deceptive, untrue, or fraudulent representations in the practice of a profession licensed . . . under this chapter or in any document connected therewith; . . . or made a false statement . . . [to] the board;
>
> * * *
>
> (7) Engaged in any unprofessional, unethical . . . , or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term 'unprofessional conduct' shall include any departure from, or failure to conform to, the minimum standards of acceptable and prevailing medical practice . . . ;
>
> * * *
>
> (11) Committed any act of omission which is indicative of bad moral character or untrustworthiness;
>
> * * *
>
> (15) Committed an act of sexual abuse, misconduct, or exploitation of a patient . . . ;
>
> (16) Mistreated or abandoned a patient or his or her records . . . ;
>
> (17) Entered into conduct which discredits the profession;
>
> * * *
>
> (20) Failed to follow generally accepted infection control procedures . . . ;

(21) Failed to comply with federal laws and standards relating to the practice of medicine, . . . [or] the regulation of drugs . . . .

O.C.G.A. § 43-34-8(a)(2), (7), (11), (15), (16), (17), (20), (21).

5.

The Board established by a preponderance of the evidence that Respondent knowingly made misleading, deceptive, untrue, or fraudulent representations in the practice of his profession, in a purported medical record and to the Board in violation of Georgia Code Section 43-34-8(a)(2). Respondent misrepresented information in the purported Incident Progress Note when he stated that A.K. came to him for the purpose of gaining weight and due to irregular menstrual cycles. This appears to be an after-the-fact fabrication of the treatment he gave A.K. on April 12, 2013. A.K. credibly testified that she did not request anything to regulate her menstrual cycle and she did not seek Depo-Provera from Respondent. Furthermore, at the time of A.K.'s adverse reaction to whatever Respondent injected her with, he said nothing to the EMS personnel or the emergency room physician about Depo-Provera, irregular menstrual cycles, or A.K. wanting to gain weight. Additionally, A.K. credibly testified that she was not using any illicit or illegal drugs at the time she received the injections from Respondent. The urine drug screen at Northside Hospital was negative for any of the tested drugs. Thus, Respondent's statement that "there appears to be undisclosed drug use by [A.K.]" has no basis in fact. Finally, Respondent's statement to the Board, through his attorney, that L.C. was not a patient was patently false. He prescribed multiple medications for her over several years. He also ordered tests, obtained blood work, performed an ultrasound, and gave her at least two trigger point injections. These actions also constitute acts or omissions which are indicative of untrustworthiness in violation of Georgia Code Section 43-34-8(a)(11) and conduct which discredits the medical profession in violation of Georgia Code Section 43-34-8(17).

6.

The Board proved by a preponderance of the evidence that Respondent's care and treatment of L.C. and A.K. failed to conform to the minimum standards of acceptable and prevailing medical practice in violation of Georgia Code Section 43-34-8(a)(7) and Board Rule 360-3-.02(18). As noted above, Respondent failed to maintain medical records for L.C. when he prescribed medications for her, including controlled substances. He failed to maintain medical records when he ordered or referred her for the breast ultrasound and diagnostic mammogram or when he performed the ultrasound and blood work during her pregnancy. Respondent was involved in a sexual relationship with L.C. while he treated her as a patient on more than an urgent basis. With regard to A.K., Respondent performed a gynecological examination on A.K. without a female chaperone, he had sex with her after he performed the examination, and he failed to date her purported medical record (i.e., the Incident Progress Report).[17]

7.

The Board proved by a preponderance of the evidence that Respondent violated Georgia Code Section 43-34-8(a)(15) and Board Rule 360-3-.02(8) when he had sex with A.K. in his examination room after he performed a gynecological examination.[18] When Respondent performed the gynecological examination on A.K., she was a patient. When he had sex with her in the

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[17] Respondent's failure to have a chaperone present while conducting the gynecological examination of A.K. was not only a violation of the standard of care, it was also a violation of Board Rule 360-3-.02(12).

[18] Board Rule 360-3-.02(8) provides that unprofessional conduct includes:

> (8) Committing any act of sexual intimacy, abuse, misconduct, or exploitation of any individual related to the physician's practice of medicine regardless of consent. The rule shall apply to former patients where the licensee did not terminate in writing the physician patient relationship before engaging in a romantic or sexual relationship with the patient and/or where the licensee used or exploited the trust, knowledge, emotions or influence derived from the prior professional relationship. The Board will consider the physician patient relationship terminated if the physician has not evaluated or treated the patient for a period of at least two (2) years.

Ga. Comp. R. & Regs. 360-3-.02(8).

examination room after the exam, he exploited A.K.'s trust and emotions, and the influence he had as a physician. This behavior also constitutes conduct which discredits the medical profession in violation of Georgia Code Section 43-34-8(17).

8.

The Board proved by a preponderance of the evidence that Respondent mistreated L.C. and A.K. He mistreated L.C. when he refused to provide her with her medical records. He acknowledged that he had the records during their conversation on February 25, 2013, but that he could not provide them to her until the Board's investigation died down. He mistreated A.K. when he had sex with her after her gynecological exam, when he refused to provide her medical records, and when he fabricated information in her purported medical record. Accordingly, the Board proved that Respondent violated Georgia Code Section 43-34-8(a)(16).

9.

The Board failed to present sufficient evidence that Respondent failed to follow generally accepted infection control procedures or that he failed to the CDC recommendations for preventing the transmission of HIV, Hepatitis C, and tuberculosis. Accordingly, the Board failed to establish violations of Georgia Code Section 43-34-8(a)(20) or Board Rule 360-3-.02(10).

10.

The Board did not allege or produce evidence of violations of any specific federal laws or standards relating to the practice of medicine or the regulations of drugs. Accordingly, the Board failed to prove a violation of Georgia Code Section 43-34-8(a)(21).

11.

Similarly, in the Matters Asserted the Board cited Board Rule 360-3-.03, which provides that the Board may take disciplinary action for violation of laws and rules that regulate the practice of

medicine, including but not limited to:

(1) The Georgia Medical Practice Act (O.C.G.A. T. 43, Ch. 34);
(2) The Georgia Controlled Substances Act (O.C.G.A. T. 16, Ch. 13, Art. 2);
(3) The Georgia Dangerous Drug Act (O.C.G.A. T. 16, Ch. 13, Art. 3);
(4) The Federal Controlled Substances Act (21 U.S.C. Ch. 13);
(5) The Georgia Pharmacists and Pharmacies Act (O.C.G.A. T. 26, Ch. 4);
(6) The Rules of the Georgia Composite Medical Board, Ch. 360, Rules and Regulations of the State of Georgia;
(7) The Rules of the Georgia State Board of Pharmacy, Ch. 480, Rules and Regulations of the State of Georgia, in particular those relating to the prescribing and dispensing of drugs;
(8) The Code of Federal Regulations Relating to Controlled Substances (21 C.F.R. par. 1306); and
(9) O.C.G.A. 31-9-6.1 and Chapter 360-14 of the rules of the Georgia Composite Medical Board relating to informed consent.

Ga. Comp. R. & Regs. 360-3-.03. However, the Board failed to allege or prove any specific violations of the Georgia Controlled Substances Act, the Georgia Dangerous Drug Act, the Federal Controlled Substances Act, the Georgia Pharmacists and Pharmacies Act, the Rules of the Georgia State Board of Pharmacy, or the Code of Federal Regulations Relating to Controlled Substances. Therefore, no violations were established under these laws and rules. The Board did allege specific violations of the Georgia Medical Practice Act, the Rules of the Composite Medical Board, and the law and rules regarding informed consent. Those alleged violations are addressed elsewhere in this decision.

12.

The Board alleged that Respondent violated Board Rule 360-3-.02(9) because he failed to comply with Georgia Code Section 31-9-6.1 and Chapter 360-14 of the Board's Rules relating to informed consent. Section 31-9-6.1 and Chapter 360-14 require informed consent to be obtained regarding surgical procedures under general anesthesia, spinal anesthesia, or major regional anesthesia or other procedures that are not relevant in this matter. O.C.G.A. 31-9-6.1; Ga. Comp. R.

& Regs. 360-14-.03. The only such procedure at issue in this matter was L.C.'s liposuction. However, the evidence was insufficient to prove that Respondent did, in fact, perform the procedure. Therefore, Respondent failed to prove a violation of Board Rule 360-3-.02(9).

13.

The Board also alleged that Respondent engaged in unprofessional conduct in violation of the following subsections of Board Rule 360-3-.02:

> (11) Failing to timely respond to an investigative subpoena issued by the Board;
>
> (14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem;
>
> (15) Failing to use medications and other modalities based on generally accepted or approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction in the treatment of patients. However, nothing herein shall be interpreted to prohibit investigations conducted under protocols approved by a state medical institution permitted by DHS and with human subject review under the guidelines of the United States Department of Health and Human Services;.
>
> (16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.
>
> (a) A physician shall be required to maintain a patient's complete medical record, which may include, but is not limited to, the following: history and physical, progress notes, X-ray reports, photographs, laboratory reports, and other reports as may be required by provision of the law. A physician shall be required to maintain a patient's complete treatment records for a period of no less than 10 years from the patient's last office visit; and
>
> (19) Providing a false, deceptive or misleading statement(s) as a medical expert.

Ga. Comp. R. & Regs. 360-3-.02(11), (14), (15), (16)(a), (19).

14.

The Board proved by a preponderance of the evidence that Respondent failed to timely respond to the Board's investigative subpoena with regard to A.K. The January 21, 2014 subpoena

was clearly received by Respondent, as it is referenced in his attorney's February 3, 2014 letter. However, no medical records were produced until May 8, 2014, despite the fact that Respondent's attorney acknowledged, on March 28, 2014, that he believed Respondent had some cursory notes. Accordingly, the Board established a violation of Board Rule 360-3-.02(11).

15.

Respondent produced no medical records for L.C. in response to the Board's subpoena. Further, Respondent asserted through his attorney that there were no medical records. Notwithstanding, Respondent prescribed multiple medications for L.C. over several years. He also ordered a breast ultrasound and diagnostic mammogram, performed an ultrasound and obtained blood work during her pregnancy, and gave her at least two trigger point injections as treatment for her pain associated with the MVA. Similarly, Respondent produced no medical records for the gynecological examination and Pap smear that he performed on A.K. Respondent's failure to document these patients' history, physical examinations, the results of laboratory tests, and the course of these patients' evaluations, treatments, and responses thereto constitute violations of Board Rules 360-3-.02(14) and 360-3-.02(16)(a).

16.

The Board alleged that Respondent violated Board Rule 360-3-.02(15). To establish a violation of this rule, the Board must prove that the physician failed to use medications and other modalities based on generally accepted or approved indications. Dr. Hill testified that the only use of Depo-Provera of which he is aware is birth control. Thus, if Respondent had given A.K. Depo-Provera to gain weight and regulate her menstrual cycle when she was not seeking birth control, then that would not have been a generally accepted or approved indication. However, as noted above, the undersigned found that Respondent did not inject A.K. with Depo-Provera. With regard to using the

normal saline to plump up A.K.'s butt, there was insufficient evidence that such a modality is not generally accepted. In other words, there is simply an absence of proof. For these reasons, the undersigned concludes that the Board failed to establish a violation of Board Rule 360-3-.02(15).

17.

Finally, the Board alleged a violation of Board Rule 360-3-.02(19). To establish a violation of this rule, the Board must prove that Respondent provided a false, deceptive, or misleading statement as a medical expert. The Board presented no evidence of when Respondent may have been acting in the capacity of a medical expert. Accordingly, the Board failed to establish a violation of Board Rule 360-3-.02(19).

Sanction

18.

Georgia Code section 43-34-8(b) authorizes the Board to discipline a licensee upon a finding that the licensee has engaged in unprofessional conduct or has violated the Boards rules. When the Board finds that a physician should be disciplined, it may suspend (for a definite or indefinite period), revoke, limit, or restrict a license; administer a public or private reprimand; make an adverse finding, but withhold imposition of judgment; or impose the judgment but suspend the enforcement of such judgment and place the physician on probation. Further, the Board may vacate any probation if the physician fails to comply with reasonable terms imposed by the Board. O.C.G.A. § 43-34-8(b). Finally, the Board may impose a fine of up to $3000.00 for each violation of law, rule or regulation, or in a reasonable amount to reimburse the Board for administrative costs. O.C.G.A. § 43-34-8(b)(1)(G), (H).

19.

Respondent engaged in unprofessional behavior in violation of Georgia Code Sections 43-34-

8(a)(2), (7), (11), (15), (16), (17) and Board Rules 360-3-.02(8), (11), (14), (16)(a), (18). Respondent's conduct with regard to these two patients was egregious. He blurred the lines between girlfriend and patient. It appears that he was using his medical license as a means to garner favor with these women. He was cavalier in prescribing medications, including controlled substances for his girlfriend L.C. He did not document any objective data to justify the prescriptions. Further, the volatility of his relationship with L.C. exemplifies why it is inappropriate to provide more than urgent treatment for a person with whom the physician is having a sexual relationship. He used the promise of providing L.C. with her medical records as a means to get her to meet him for lunch after their relationship ended. Then, because he knew that he probably should not have been treating her, he refused to give her the medical records because he did not want to get "in trouble" with the Board. He took advantage of these women. He convinced A.K. to have sex with him in his examination room after performing a gynecological examination on her. His failure to document the gynecological examination of A.K. is particularly troubling given her history of cervical cancer. Additionally, after A.K.'s adverse reaction to whatever he injected her with, Respondent fabricated a supposed medical record, in which he, without factual basis, asserted that "there appears to be undisclosed drug use."[19] Finally, Respondent lied to the Board and attempted to avoid the Board's inquiry. Respondent's conduct constitutes more than sufficient grounds to sanction Respondent's medical license. Given the reprehensible nature of Respondent's conduct, the undersigned concludes that revocation is the appropriate sanction.

ORDER

For the above and foregoing reasons, Respondent's medical license is hereby **REVOKED**.

[19] Respondent's allegation that an individual is using illicit or illegal drugs appears to be his modus operandi when he is having a conflict with that individual. He did the same thing when he called the police with fabricated allegations against L.C. on December 24, 2012.

SO ORDERED, this 18th day of June, 2018.

STEPHANIE M. HOWELLS
Administrative Law Judge

BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
STATE OF GEORGIA

IN THE MATTER OF : *

JOHN YOLMAN SALINAS, M.D. * **DOCKET NO. 2003-0030**
License No. ~~19086~~ 38600 km *

Respondent.
*

FINAL DECISION

An INITIAL DECISION(decision)of Special Assistant Administrative Law Judge Randall K. Coggin was filed in the above matter on November 20, 2002. The Respondent filed for Review on December 20, 2002. Pursuant to this motion, a hearing was scheduled before the Composite State Board of Medical Examiners at 11:00 a.m., on January 10, 2003.

The parties hereto were given notice of the hearing and the hearing was conducted. Dr. Lynette Stewart recused herself from this decision. As a consequence of the hearing, the Board finds as follows:

FINDINGS OF FACT

The Findings of Fact found by the Special Assistant Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law reached by the Special Assistant Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein with the following modifications:

In paragraph three (3) of the Conclusions of Law, the cite should. read O.C.G.A. 43-

34-37(a)(3) and (a)(4) ; And

In paragraph four (4) of the Conclusions of Law, the cite should read O.C.G.A. 43-1-19 (a)(3) and (a)(4).

ORDER

The Sanctions recommended by the Special Assistant Administrative Law Judge in the Initial Decision are hereby adopted, incorporated by reference herein and made the Sanctions of the Board with the following modifications:

Based on the fact that there are no quality of care or impairment issues, the Board rescinds the public reprimand and the probation period of one year. Further, the Board reduces the fine amount to one dollar ($1.00).

The effective date is the docketing date of this Final Decision.

IT IS **SO ORDERED** this 16th day of January, 2003.

COMPOSITE BOARD OF MEDICAL EXAMINERS
STATE OF GEORGIA

EDDIE R. CHEEKS, M.D.
PRESIDENT

KAREN A. MASON
EXECUTIVE DIRECTOR
COMPOSITE BOARD OF MEDICAL EXAMINERS

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS,
Petitioner,

v.

JOHN Y. SALINAS,
Respondent.

DOCKET NUMBER -200300
Docket No.: OSAH-CSBME-PHY-0306906-44-RC

Agency Reference Number:

INITIAL DECISION AND ORDER ON MOTION FOR SUMMARY DETERMINATION

I. INTRODUCTION

Petitioner in the above-styled action has filed a Motion for Summary Determination, to which the Respondent has filed no response within the allotted time set out by OSAH Rules 616-1-2-.15 and 616-1-2-.16. After review of the motion submitted by Petitioner, the Court finds and concludes as follows:

II. FINDINGS OF FACT

1.

Respondent is licensed as a physician in the State of Georgia and has been so licensed since June 2, 1994. *Petitioner's Motion for Summary Determination, Exhibit A.*

2.

On May 17, 2002, the Respondent entered a plea of guilty to the offenses of Tax Evasion and Theft by Taking (misdemeanor) in the Superior Court of DeKalb County, Georgia in Accusation No. 02-CR-1823-4. The Respondent was sentenced to a period of three years and allowed to serve the sentence under the First Offender Act. *Petitioner's Motion for Summary Determination, Exhibit B.*

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III. CONCLUSIONS OF LAW

1.

This case involves an action by the Petitioner to sanction the license of the Respondent, therefore, the burden of going forward and the burden of persuasion is on the Petitioner as the referring agency. The evidentiary standard is a preponderance of the evidence. *OSAH Rule 616-1-2-.21(4)*

2.

"When a motion for summary determination is made and supported as provided in this Rule, a party opposing the motion...must show, by affidavit or other probative evidence, that there is a genuine issue of material fact for determination at the hearing." *OSAH Rule 616-1-2-.15* No such response has been filed by the Respondent in this case.

3.

The Petitioner has the authority to sanction the Respondent's license if the Respondent has been convicted of a felony pursuant to O.C.G.A.§ 43-34-37 (a)(4). The conviction of Respondent for Tax Evasion, O.C.G.A. § 48-7-5, constitutes a felony offense.

4.

Additionally, the term "conviction" as defined in O.C.G.A. § 43-1-19 (a)(4) specifically encompasses First Offender Treatment, by providing that the term shall apply even if adjudication is withheld.

5.

As a result of Respondent's commission of the felony offense set forth above, he has violated the applicable code sections governing the practice of medicine, and is liable to such sanction as the Petitioner may impose.

IV. DECISION

The Petitioner's Motion for Summary Determination, having set forth sufficient grounds is hereby GRANTED, and the Respondent's license to practice medicine is hereby SANCTIONED as follows: Respondent shall receive a public reprimand, be fined in the amount of $500.00, and Respondent's medical license shall be placed on probation for a period of one year from the date of this order.

SO ORDERED this 19th day of November, 2002.

Randall K. Coggin
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS,
Petitioner,

v.

JOHN YOLMAN SALINAS, M.D.,
Respondent.

Docket No.: OSAH-CSBME-PHY-0306906-44-RC

NOTICE OF HEARING

The Office of State Administrative Hearings (OSAH) is an independent state agency that conducts hearings in contested cases involving state agencies. **Administrative Law Judge RANDALL K. COGGIN** has been assigned to this case. All questions concerning the hearing may be made to the Judge's assistant at the Office of State Administrative Hearings (OSAH), **CONNIE JONES**, 235 Peachtree Street, NE, The North Tower, Suite 700, Atlanta, Georgia 30303-1402, telephone number **(404) 651-7595** and fax number **(404) 818-3753. A copy of all submissions to OSAH must also be sent at the same time to the opposing party as required by OSAH Rule 616-1-2-.11(1).** Additional information may also be obtained at ***www.ganet.org/osah.***

1. DATE, TIME AND LOCATION OF HEARING: The administrative hearing will be held on **December 09, 2002, at 02:00 PM, at OSAH HEARING ROOM, SUITE 700, 235 PEACHTREE STREET NE, ATLANTA, GA.** Any party who believes that another location would be more appropriate may file a written motion for a change in the hearing location. Any such request must be filed in writing with the Judge's assistant no less than five days prior to the hearing. **Unless the Judge specifically grants a motion, the hearing will be held as set out in this notice.**

2. FAILURE TO ATTEND HEARING: Unless the Judge has excused a party, the party's failure to appear for the hearing within 15 minutes of its scheduled time may result in a default and dismissal of the matter.

3. PURPOSE OF THE HEARING AND MATTERS ASSERTED: The purpose of the hearing is for the Judge to review issues relating to actions taken by the Board either refusing to grant a license to or disciplining a physician. A short and plain statement of the matters asserted or the issues involved is included in or attached to the OSAH Form 1 used by the agency to refer this matter to OSAH. The parties are encouraged to resolve the case informally prior to the hearing.

4. FAILURE TO FILE ANSWER: Respondent must file an answer with the agency within fourteen (14) days after service of this notice of hearing. All allegations contained in the matters asserted, that is attached to and incorporated in this notice of hearing, which are not specifically admitted are deemed denied. CSMBE Rule 360-18-.02.

5. RIGHTS OF THE PARTIES: The hearing will follow the procedures set out in the Georgia Administrative Procedure Act and OSAH Rules. Among the rights the Act and the Rules provide is the right to be represented by legal counsel and to subpoena witnesses and evidence for the hearing. Subpoenas must be requested at least five days prior to the hearing. The parties must be ready to present their case including witnesses and evidence at the hearing.

6. STATUTES AND RULES INVOLVED, OFFICIAL NOTICE: The relevant statutes are O.C.G.A. §§ 43-34-20 through 43-34-46 and the Composite State Board of Medical Examiners Rules 360-2-.01 through .11 and 360-16 through 26. A statement of the statutes and rules involved is included in the attached OSAH Form 1 and/or the statement of matters asserted. No matters are officially noticed at this time.

SO ORDERED October 24, 2002.

RANDALL K. COGGIN
Administrative Law Judge

Attachments:
Matters Asserted/OSAH Form 1
Statutes and Rules Involved

OSAH welcomes suggestions on how we can improve. Please direct any such suggestions to Ms. Karen Hampton, Human Resources Director at (404) 657-2800, or khampton@osah.state.ga.us.

GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF:

JOHN Y. SALINAS, M.D.
License No. 38600
Respondent.

BOARD DOCKET NO. 2003-0030

MATTERS ASSERTED
AND
STATUTES AND RULES INVOLVED

COMES NOW, the Georgia Composite State Board of Medical Examiners, ("Board") pursuant to O.C.G.A. § 50-13-13, and hereby provides John Y. Salinas, M.D. ("Respondent"), with the matters asserted and statutes and rules involved for purpose of a sanctioning the license of the Respondent. The matters asserted below, if correct, constitute sufficient grounds for sanctioning the license of the Respondent under the statutes and rules cited.

MATTERS ASSERTED

1.

Respondent is licensed as a physician in the State of Georgia and was so licensed at all times relevant to the matters stated herein.

2.

Respondent received a conviction in the Superior Court of Dekalb County. Georgia, Criminal Action No. 02-CR-1823, for one count of felony tax evasion and one misdemeanor count of theft by taking. The indictment stated that the Respondent unlawfully "took $45 from the Georgia Department of Community Health (DCH), to which he was not entitled, with no intent to restore it [to] DCH, by billing DCH for a January 4, 2000 medical service to Medicaid Recipient A.P. and concealing from DCH that Salinas had received $45 from private insurance for the same medical service." Finally, the indictment stated that the acts were unknown to the State of Georgia until April 11, 2001.

3.

On or about May 17, 2002, Respondent was sentenced to three (3) years probation on the felony tax evasion charge and twelve (12) months probation as to the misdemeanor theft by taking charge. Furthermore, Respondent was ordered to pay seventy thousand dollars ($80,000.00) in restitution and an eleven thousand dollar ($11,000.00) fine.

STATUTES AND RULES INVOLVED

The Georgia Composite State Board of Medical Examiners is given authority to regulate the practice of the medicine under O.C.G.A. Title 43, Chapters 1 and 34.

Under O.C.G.A. § 43-1-19(a):

> A professional licensing board shall have the authority to refuse to grant a license to an applicant therefor or to revoke the license of a person licensed by that board or to discipline a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:
>
> (3) Been convicted of any felony or of any crime involving moral turpitude in the courts of this state or any other state, territory, or country or in the courts of the United States; as used in this paragraph and paragraph (4) of this subsection, the term "felony" shall include any offense which, if committed in this state, would be deemed a felony, without regard to its designation elsewhere; and, as used in this paragraph, the term "conviction" shall include a finding or verdict of guilty or a plea of guilty, regardless of whether an appeal of the conviction has been sought;
>
> (6) Engaged in unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional conduct shall also include any departure from, or the failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title; and
>
> (8) Violated a statute, law, or any rule or regulation of this state, any other state, the professional licensing board regulating the business or profession licensed under this title, the United States, or any other lawful authority (without regard to whether the violation is

criminally punishable), which statute, law, or rule or regulation relates to or in part regulates the practice of a business or profession licensed under this title, when the licensee or applicant knows or should know that such action is violative of such statute, law, or rule; or violated a lawful order of the board previously entered by the board in a disciplinary hearing, consent decree, or license reinstatement.

O.C.G.A. § 43-1-19(d) states that:

> When a professional licensing board finds that any person is unqualified to be granted a license or finds that any person should be discipline pursuant to subsection (a) of this Code section or the laws, rules or regulations relating to the business or profession licensed by the board, the board may take one or more of the following actions:
>
> (2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;
>
> (4) Limit or restrict any license as the board deems necessary for the protection of the public; and
>
> (7) Impose a fine not to exceed $500.00 for each violation of a law, rule or regulation relating to the licensed business or profession.

Under O.C.G.A. § 43-34-37, the Board is granted specific authority to sanction licensees for violations of its laws, rules and regulations. O.C.G.A. § 43-34-37(a) states:

> The board shall have the authority to refuse to grant a license or registration to an applicant or to discipline a physician licensed under this chapter or any antecedent law upon a finding by the board that the licensee or applicant has:
>
> (2) Knowingly made misleading, deceptive, untrue, or fraudulent representations in the practice of medicine or in any document connected therewith, or practiced fraud or deceit or intentionally made any false statement in obtaining a license to practice medicine, or made a false or deceptive biennial registration with the board;
>
> (4) Committed a crime involving moral turpitude, without regard to conviction; the conviction of a crime involving moral turpitude shall be evidence of the commission of such crime. As used in this paragraph, the term "conviction" shall have the meaning prescribed in paragraph (3) of this subsection. For the purpose of this chapter, a conviction or plea of guilty or of nolo contendere to a charge or indictment by either federal or state government for income tax evasion shall not be considered a crime involving moral turpitude;
>
> (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to

the patient as determined by the minimal standards of acceptable and prevailing medical practice or by rule of the board;

(10) Violated or attempted to violate a law, rule, or regulation of this state, any other state, the board, the United States, or any other lawful authority without regard to whether the violation is criminally punishable, which law, rule, or regulation relates to or in part regulates the practice of medicine, when the licensee or applicant knows or should know that such action is violative of such law, rule, or regulation; or violated a lawful order of the board, previously entered by the board in a disciplinary hearing;

(11) Committed any act or omission which is indicative of bad moral character or untrustworthiness;

Likewise, under O.C.G.A. §§ 43-34-37(b)(1):

When the board finds that any person is unqualified to be granted a license or finds that any person should be disciplined pursuant to subsection (a) of this Code section, the board may take any one or more of the following actions:

(B) Administer a public or private reprimand, provided that a private reprimand shall not be disclosed to any person except the licensee; and

(D) Limit or restrict any license.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

EDDIE R. CHEEKS, M.D.
Chairman

Prepared by:

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